PREAUTHORIZATION PROCESS AND DOCUMENTATION REQUIRED

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and

appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICES

After Medicaid eligibility for the recipient has been established, the contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests.

They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	**Enrolled Individual**	**Comments**
Approval	X	X	
Denial/Partial Denial	X	X	Appeal Rights are included in all denials/partial denials

DMAS will not reimburse providers for dates of service prior to the date(s) identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR). Please see additional requirements in Chapter VI of this manual.

Subsequent Recertification Review

Prior to the end of the last authorized date, the provider should submit the required documents for continued preauthorization. The documentation will be reviewed to determine if it meets

DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the physician's signature and date on the certificate of medical necessity. The DMAS preauthorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the preauthorization contractor will authorize a specific number of units and dates of service based on the documentation submitted.

PREAUTHORIZATION PROCESS

General Information

Prior to requesting authorization of services under the waivers, the individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver criteria. Criteria for enrollment differ from waiver to waiver. The following chart indicates the PA entity that will accept requests for enrollment, and the alternate institutional placement. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes.

Waiver	Send Enrollment To	Alternate Institutional Placement
Elderly or Disabled with Consumer Direction (EDCD) Waiver	KePRO	Skilled Nursing Facility
AIDS/HIV Waiver	KePRO	Skilled Nursing Facility or Acute Hospital
Individual and Family Developmental Disabilities Support (IFDDS)Waiver	DMAS	Intermediate Care Facility for Mentally Retarded
Technology Assisted (Tech) Waiver	DMAS	Skilled Nursing Facility or Acute Hospital
Mental Retardation (MR) Waiver	DMHMRSAS	Intermediate Care Facility for Mentally Retarded
Day Support (DS) Waiver for Individuals with Mental Retardation	DMHMRSAS	Intermediate Care Facility for Mentally Retarded
Alzheimer's Assisted Living (AAL)Waiver	DMAS	Skilled Nursing Facility

Once enrolled in the waiver, services may be requested through the PA entity. The following chart summarizes Virginia's Home and Community Based Waivers, the services available under each waiver, and the PA entity that will review requests for services.

Waiver Services	AIDS Waiver	DD Waiver	EDCD Waiver	MR Waiver *	Tech Assisted	Day Support Waiver*	Alzheimer's Waiver	PA Entity*	Requires PA	Retroactive Authorization
Adult Companion Care – Agency		X		X				Contractor	Yes	Yes
Adult Companion Care – Consumer Directed		X		X				Contractor	Yes	Yes
Adult Day Health Care			X					Contractor	Yes	See Ch IV
Assisted Living							X	DMAS	No	No
Assistive Technology		X		X	X			Contractor	Yes	No
Congregate Residential				X				*	Yes	No
Environmental Mods		X		X	X			Contractor	Yes	No
Case Management	X							Contractor	Yes	See Ch IV
Crisis Stabilization		X		X				Contractor	Yes	See Ch IV
Day Support Regular		X		X		X		Contractor	Yes	No
Day Support High Intensity		X		X		X		Contractor	Yes	No
Family/Caregiver Training		X						Contractor	Yes	No
In-Home Residential		X		X				Contractor	Yes	No
Enteral Nutrition	X							Contractor	Yes	No
Personal Care – Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Personal Care – Consumer Directed	X	X	X	X				Contractor	Yes	Yes
PERS		X	X	X				Contractor	Yes	No
Private Duty Nursing-RN	X				X			AIDS Waiver by Contractor; Tech Waiver by DMAS	Yes	AIDS Waiver – No; Tech Waiver - Yes
Private Duty Nursing-LPN	X				X			AIDS Waiver by Contractor; Tech Waiver by DMAS	Yes	AIDS Waiver – No; Tech Waiver - Yes
Respite Care - Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Respite Care - Consumer Directed	X	X	X	X				Contractor	Yes	Yes
Skilled Nursing –RN		X		X				Contractor	Yes	No
Skilled Nursing - LPN		X		X				Contractor	Yes	No
Supported Employment-Individual		X		X				Contractor	Yes	No
Supported Employment – Enclave		X		X				Contractor	Yes	No
Therapeutic Consultation		X		X				Contractor	Yes	No
Prevocational Services (all)		X		X		X		Contractor	Yes	No
PERS RN		X	X	X				Contractor	Yes	No

PERS LPN		X	X	X				Contractor	Yes	No
Crisis Supervision		X		X				Contractor	Yes	See Ch IV
PERS Installation		X	X	X				Contractor	Yes	No
Service Facilitation Visits (all)	X	X	X	X				N/A	No	Yes

All Waiver Services requested under the Mental Retardation Waiver and the Day Support Waiver are processed through DMHMRSAS.
****Enrollments to the DD, Tech, and Alzheimer's Waivers are performed by DMAS.***
*****Once the individual is successfully enrolled by DMAS in the DD and Tech Waivers, the service requests are processed through the contractor.***
Contractor = KePRO

Preauthorization for HIV/AIDS Waiver Services

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	Case Manager	Enrolled Individual	Comments
Approval	X	X	X	
Pend	X	X		
Reject	X	X		
Denial/Partial Denial	X	X	X	Appeal Rights are included in all denials/partial denials

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR).

If available, and the recipient has chosen to receive case management services, all service requests must be submitted through the Case Manager. If services are not requested within 10 business days of start of care or 10 business days of the provider's receipt of verification of Medicaid eligibility (DMAS-122), approvals will begin on the day the request was received by the contractor.

Plans of Care and Service Authorizations

After the individual has been received an assessment by the local Pre-Admission Screening Team and determined to be eligible and appropriate for HIV/AIDS Waiver services, a referral is made to the provider of the recipient's choice. The provider performs an assessment, and if

determined to continue to meet eligibility criteria, develops a plan of care (POC). The request for services is submitted to the contractor for authorization, with all of the supporting information as required (see Chapter IV)

Submitting Requests for Services

After the individual is successfully enrolled the provider may begin submitting requests. The contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests. They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The following chart shows the information necessary to process the request for specific services. Although these forms may not be required by the contractor, pertinent information from these forms will be required to process the request. Upon QMR of the provider or case management agency, the forms must be present in the record and fully completed. These documents will be compared against the information submitted to the contractor. In addition, the contractor may require a daily schedule of the individual.

HCPCS code	Description	PA Required	PA Units Requested	PA Units Approved	Service limits	Units	Forms currently submitted for authorization
T1016	Case Management	Y	Month	Month	10	Units	DMAS-99, DMAS-114
T1002	Skilled Nursing Services, RN	Y	Day/Week	Month	Max 16 hours/day	Hour	DMAS-99, CMS 485 Nursing plan of care signed by MD (Q2Months), DMAS-114 if submitted by CM
T1003	Skilled Nursing Services, LPN	Y	Day/Week	Month	Max 16 hours/day	Hour	DMAS- 99, CMS 485 Nursing plan of care signed by MD (Q2Months), DMAS-114 if submitted by CM
T1019	Agency Personal Care	Y	Week	Month	**	Hour	DMAS-97A/B, DMAS 99, DMAS-114 if submitted by CM
	Supervision Component	Y	Week		**	Hour	DMAS-100
S5126	CD Personal Care	Y	Week	Bi-Weekly	**	Hour	DMAS-97A/B, DMAS-99, DMAS-95 Addendum if directing own care, DMAS-114 if submitted by CM
	Supervision Component	Y	Week		**	Hour	DMAS-100
H2000	Initial Comprehensive Visit-CD	N	N/A	N/A	1/Entry into CD Services	Unit	N/A

S5109	Consumer Training-CD	N	N/A	N/A	1/Provider	Unit	N/A
99509	Routine Visit-CD	N	N/A	N/A	1/30 Days	Unit	N/A
99199 U1	Criminal Record Check-CD	N	N/A	N/A	No Limit	Unit	N/A
T1028	Reassessment Visit-CD	N	N/A	N/A	2/6 Months	Unit	N/A
S5116	Management Training-CD	N	N/A	N/A	No Limit	Unit	N/A
99199	CPS Registry Check-CD	N	N/A	N/A	No Limits	Unit	N/A
T1005	Agency Respite Care Services, Aide	Y	Year	Year	720 Hrs/Calendar Yr (all types RCS combined)	Hour	DMAS-97A/B, DMAS-99, DMAS-300 if sole service, DMAS-114 if submitted by CM
S9125	Agency Respite Care Services, Skilled	Y	Year	Year	720 Hrs/Calendar Yr (all types RCS combined)	Hour	DMAS-97A/B, DMAS-99, DMAS-300 signed by MD, DMAS-114 if submitted by CM
S5150	CD Respite	Y	Year	Year	720 Hrs/Calendar Yr	Hour	DMAS-97A/B, DMAS-99, DMAS-95 Addendum if directing own care, DMAS-300 if sole service, DMAS-114 if submitted by CM
B4154	Enteral Nutrition	N					

* *All forms are located on the DMAS web site at www.dmas.virginia.gov.*
** *See Chapter IV*

PRIOR AUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

Provider Appeals

If services are denied by the preauthorization contractor the provider may request a reconsideration within 30 days of the receipt of the notice of denial by submitting a request to KePRO.

If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the denial. The notice is considered filed when it is date stamped by the Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th floor
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

After completion of the reconsideration process, the denial of pre-authorization for services not yet rendered may be appealed in writing by the Medicaid client by sending a written request for an appeal within 30 days of the receipt of the notice of denial. The client or the client's authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the denial. The notice is considered filed when it is date stamped by the Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th floor
Richmond, Virginia 23219